DEPARTMENT OF
INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

SEATING AND POSITIONING CLINIC REFERRAL

West TN Clinic
Phone: (901) 745-7509
Fax: (901) 745-7742
Email

Middle TN Clinic
Phone: (615) 231-5147
Fax: (615) 886-9972
Email

East TN Clinic
Phone: (423) 787-6689
Fax: (423) 798-6220
Email

PLEASE SELECT ONE: ___ Waiver ___ State ICF/IID ___ Private ICF/IID ___ Other

PHYSICIAN ORDERS:

We require a physician's order to provide services. The order needs to be less than one year old and should state, "*Seating and Positioning Clinic to evaluate and treat for wheelchair, positioning equipment, and/or repairs.*" Please include with this form.

INSURANCE: Please attach copies of the front and back of all current medical insurance cards and send in with your paperwork.

Name: _____ Date of Referral: _____

Social Security Number _____ Date of Birth: _____

Mailing Address _____ Phone: _____

Supporting Agency: _____

CONTACT INFORMATION (for scheduling)

Name: _____ Phone: _____ Email: _____

PRIMARY CARE PHYSICIAN (PCP)

Name: _____ Phone: _____ Fax: _____

INDEPENDENT SUPPORT COORDINATOR / CASE MANAGER (if has one)

Name: _____ Phone: _____ Email: _____

OCCUPATIONAL THERAPIST (if has one)

Name: _____ Phone: _____ Email: _____

PHYSICAL THERAPIST (if has one)

Name: _____ Phone: _____ Email: _____

___ Repair ___ Evaluation ___ Other *(Explain)*: _____

DESCRIBE THE REPAIR / EVALUATION NEEDED:

DIAGNOSES (may attach list if available) **:**

CURRENT MEDICATIONS (may attach list if available) **:**

OFFICE USE ONLY See TIMS for Notes

COMMENTS: COMPLETED BY: